
Afghanistan &
Iraq War Veterans
Click to learn more

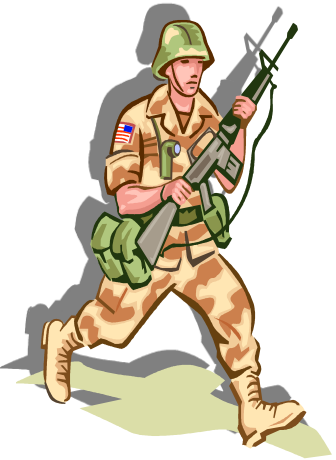
VA Health and Dental Care

for Veterans of Operations Enduring & Iraqi Freedom

Veterans of Operations Enduring & Iraqi Freedom

VA provides enhanced enrollment opportunity and **five years of cost-free health care** to veterans who served in a theater of combat operations, for any injury or illness associated with this service

Application Process

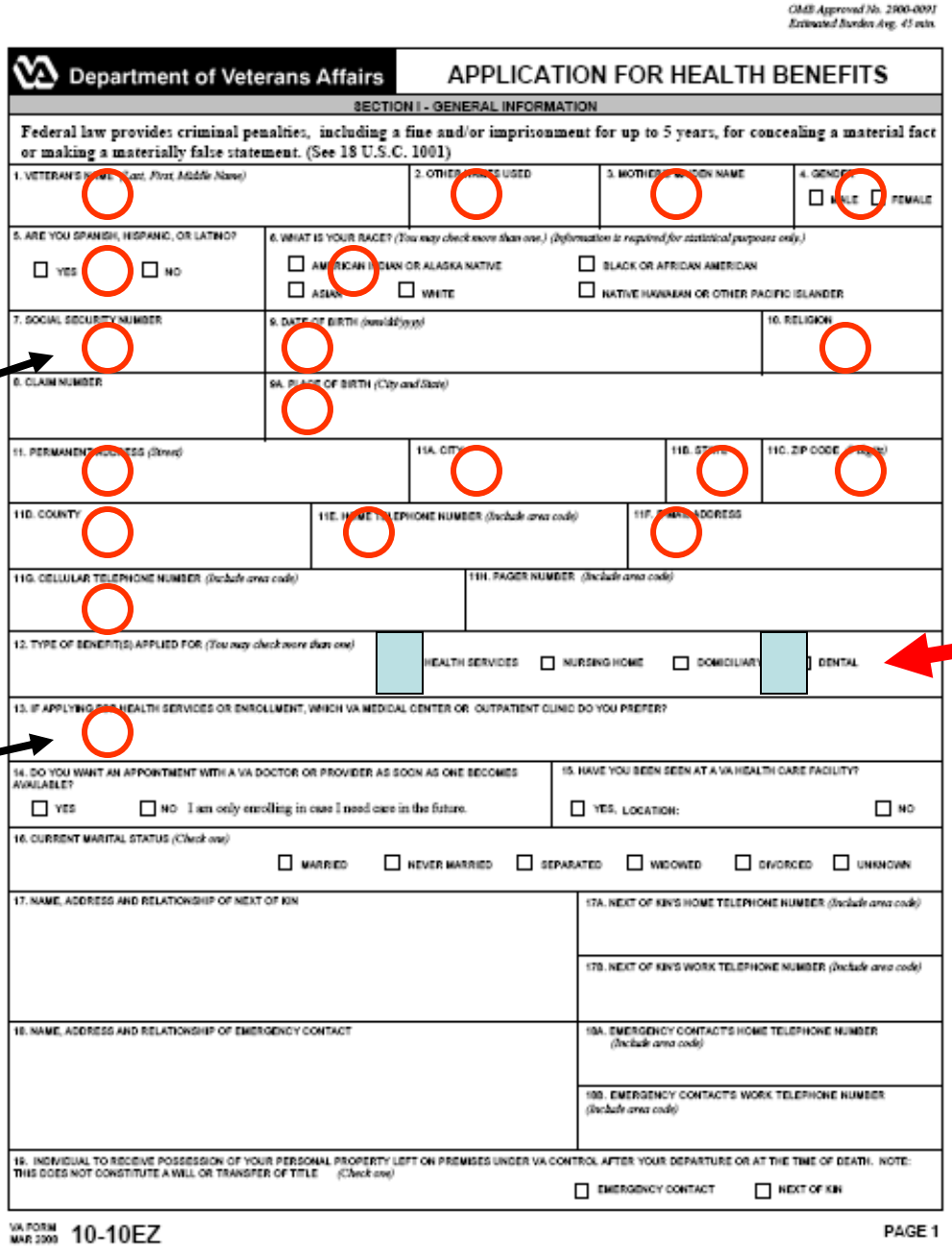


- Identify VA medical center for visit to primary care
- Complete VA Form 10-10EZ
- Submit 10-10EZ to VA Enrollment Specialist at end of presentation
- Additional Questions:
  - Call **1-877-222-VETS (8387**) or
  - **Visit www.va.gov**

Section I
General Information
Complete
Parts
1 -7 and 9- 11G

Select
Block 13
VA medical facility
to receive care

VA Form 10-10 EZ



OMB Approved No. 2900-0091
Estimated Burden Avg. 45 min.

Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

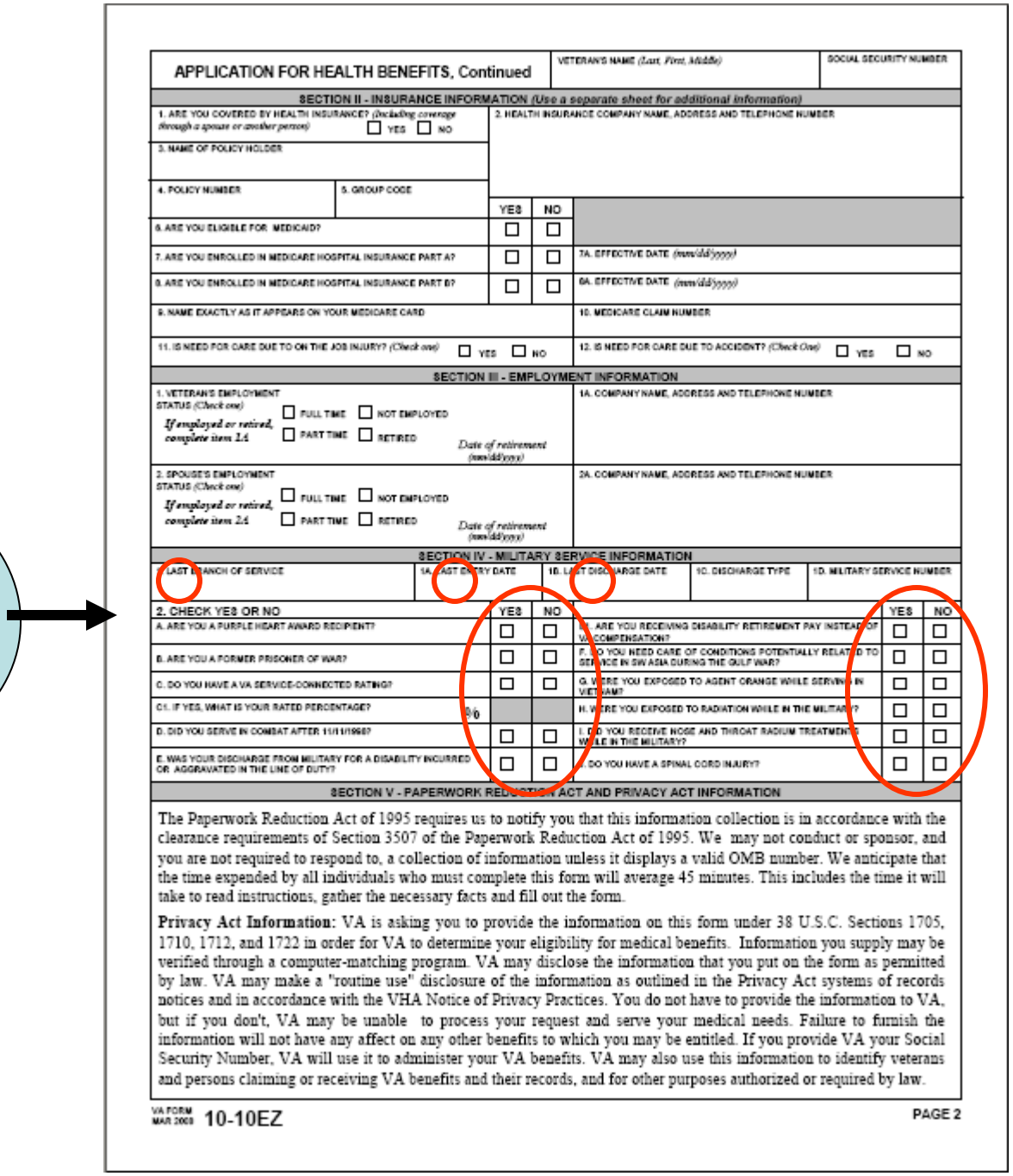
1. VETERAN'S NAME (Last, First, Middle Name)
2. OTHER NAMES USED
3. MOTHER'S MAIDEN NAME
4. GENDER ☐ MALE ☐ FEMALE
5. ARE YOU SPANISH, HISPANIC, OR LATINO? ☐ YES ☐ NO
6. WHAT IS YOUR RACE? (You may check more than one.) (Information is required for statistical purposes only.) ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ BLACK OR AFRICAN AMERICAN ☐ ASIAN ☐ WHITE ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
7. SOCIAL SECURITY NUMBER
8. DATE OF BIRTH (mm/dd/yyyy)
10. RELIGION
9. CLAIM NUMBER
9A. PLACE OF BIRTH (City and State)
11. PERMANENT ADDRESS (Street)
11A. CITY
11B. STATE
11C. ZIP CODE (+4 if applicable)
11D. COUNTY
11E. HOME TELEPHONE NUMBER (Include area code)
11F. E-MAIL ADDRESS
11G. CELLULAR TELEPHONE NUMBER (Include area code)
11H. PAGER NUMBER (Include area code)
12. TYPE OF BENEFIT(S) APPLIED FOR (You may check more than one) ☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL
13. IF APPLYING FOR HEALTH SERVICES OR ENROLLMENT, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER?
14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? ☐ YES ☐ NO I am only enrolling in case I need care in the future.
15. HAVE YOU BEEN SEEN AT A VA HEALTH CARE FACILITY? ☐ YES, LOCATION: ☐ NO
16. CURRENT MARITAL STATUS (Check one) ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN
17. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN
17A. NEXT OF KIN'S HOME TELEPHONE NUMBER (Include area code)
17B. NEXT OF KIN'S WORK TELEPHONE NUMBER (Include area code)
18. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT
18A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (Include area code)
18B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (Include area code)
19. INDIVIDUAL TO RECEIVE POSSESSION OF YOUR PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER YOUR DEPARTURE OR AT THE TIME OF DEATH. NOTE: THIS DOES NOT CONSTITUTE A WILL OR TRANSFER OF TITLE (Check one) ☐ EMERGENCY CONTACT ☐ NEXT OF KIN

VA FORM MAR 2000 10-10EZ PAGE 1

Block 12

☑ Medical
☑ Dental

Section IV
Complete
Military Service Information



APPLICATION FOR HEALTH BENEFITS, Continued

VETERAN'S NAME (Last, First, Middle) | SOCIAL SECURITY NUMBER

SECTION II - INSURANCE INFORMATION *(Use a separate sheet for additional information)*

1. ARE YOU COVERED BY HEALTH INSURANCE? *(Including coverage through a spouse or another person)* ☐ YES ☐ NO
2. HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER
3. NAME OF POLICY HOLDER
4. POLICY NUMBER
5. GROUP CODE

	YES	NO	
6. ARE YOU ELIGIBLE FOR MEDICAID?	☐	☐	
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A?	☐	☐	7A. EFFECTIVE DATE *(mm/dd/yyyy)*
8. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B?	☐	☐	8A. EFFECTIVE DATE *(mm/dd/yyyy)*

9. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD
10. MEDICARE CLAIM NUMBER
11. IS NEED FOR CARE DUE TO ON THE JOB INJURY? *(Check one)* ☐ YES ☐ NO
12. IS NEED FOR CARE DUE TO ACCIDENT? *(Check One)* ☐ YES ☐ NO

SECTION III - EMPLOYMENT INFORMATION

1. VETERAN'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED
If employed or retired, complete item 2A — *Date of retirement (mm/dd/yyyy)*
1A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

2. SPOUSE'S EMPLOYMENT STATUS *(Check one)* ☐ FULL TIME ☐ NOT EMPLOYED ☐ PART TIME ☐ RETIRED
If employed or retired, complete item 2A — *Date of retirement (mm/dd/yyyy)*
2A. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

SECTION IV - MILITARY SERVICE INFORMATION

1. LAST BRANCH OF SERVICE | 1A. LAST ENTRY DATE | 1B. LAST DISCHARGE DATE | 1C. DISCHARGE TYPE | 1D. MILITARY SERVICE NUMBER

2. CHECK YES OR NO	YES	NO		YES	NO
A. ARE YOU A PURPLE HEART AWARD RECIPIENT?	☐	☐	E. ARE YOU RECEIVING DISABILITY RETIREMENT PAY INSTEAD OF VA COMPENSATION?	☐	☐
B. ARE YOU A FORMER PRISONER OF WAR?	☐	☐	F. DO YOU NEED CARE OF CONDITIONS POTENTIALLY RELATED TO SERVICE IN SW ASIA DURING THE GULF WAR?	☐	☐
C. DO YOU HAVE A VA SERVICE-CONNECTED RATING?	☐	☐	G. WERE YOU EXPOSED TO AGENT ORANGE WHILE SERVING IN VIETNAM?	☐	☐
C1. IF YES, WHAT IS YOUR RATED PERCENTAGE?	%		H. WERE YOU EXPOSED TO RADIATION WHILE IN THE MILITARY?	☐	☐
D. DID YOU SERVE IN COMBAT AFTER 11/11/1998?	☐	☐	I. DID YOU RECEIVE NOSE AND THROAT RADIUM TREATMENTS WHILE IN THE MILITARY?	☐	☐
E. WAS YOUR DISCHARGE FROM MILITARY FOR A DISABILITY INCURRED OR AGGRAVATED IN THE LINE OF DUTY?	☐	☐	J. DO YOU HAVE A SPINAL CORD INJURY?	☐	☐

SECTION V - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA may be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

Section VI
Financial Disclosure

☑ **NO**

Section XII
Assignment of Benefits
Sign and Date

APPLICATION FOR HEALTH BENEFITS, Continued

VETERAN'S NAME (*Last, First, Middle*) | SOCIAL SECURITY NUMBER

SECTION VI - FINANCIAL DISCLOSURE

Disclosure allows VA to accurately determine whether certain veterans will be charged copayments for care and medications, their eligibility for other services and enrollment priority. Veterans are not required to disclose their financial information; however, VA is not currently enrolling new applicants who decline to provide their financial information unless they have a special eligibility factor. **Recent combat veterans (e.g., OEF/OIF) who were discharged within the past 5 years or were discharged more than 5 years ago and applying for enrollment by Jan. 27, 2011 are eligible for enrollment without disclosing their financial information** but like other veterans may provide it to establish their eligibility for travel reimbursement, cost-free medication and/or medical care for services unrelated to military experience.

☐ **No, I do not wish to provide financial information in Sections VII through X.** I understand that VA is not enrolling new applicants who do not provide this information and who do not have a special eligibility factor (e.g., recently discharged combat veteran, compensable service connection, receipt of VA pension or Medicaid benefits.) If I am enrolled, I agree to pay applicable VA copayments. *Sign and date the form in Section XII.*

☐ **Yes, I will provide my household financial information for last calendar year.** Complete applicable sections VII through X. *Sign and date the form in Section XII.*

SECTION VII - DEPENDENT INFORMATION *(Use a separate sheet for additional dependents)*

1. SPOUSE'S NAME (*Last, First, Middle Name*)
2. CHILD'S NAME (*Last, First, Middle Name*)
1A. SPOUSE'S MAIDEN NAME
2A. CHILD'S RELATIONSHIP TO YOU (*Check one*) ☐ Son ☐ Daughter ☐ Stepson ☐ Stepdaughter
1B. SPOUSE'S SOCIAL SECURITY NUMBER
2B. CHILD'S SOCIAL SECURITY NUMBER
2C. DATE CHILD BECAME YOUR DEPENDENT (*mm/dd/yyyy*)
1C. SPOUSE'S DATE OF BIRTH (*mm/dd/yyyy*)
1D. DATE OF MARRIAGE (*mm/dd/yyyy*)
2D. CHILD'S DATE OF BIRTH (*mm/dd/yyyy*)
1E. SPOUSE'S ADDRESS AND TELEPHONE NUMBER (*Street, City, State, ZIP*)
2E. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO
2F. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO
3. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT. SPOUSE $ CHILD $
2G. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (*e.g., tuition, books, materials*) $

SECTION VIII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT (*wages, bonuses, tips, etc.*) EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	$	$	$
3. LIST OTHER INCOME AMOUNTS (*e.g., Social Security, compensation, pension interest, dividends*). EXCLUDING WELFARE.	$	$	$

SECTION IX - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (*e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home*) VA will calculate a deductible and the net medical expenses you may claim.	$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (*Also enter spouse or child's information in Section VII.*)	$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (*e.g., tuition, books, fees, materials*) *DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.*	$

SECTION X - PREVIOUS CALENDAR YEAR NET WORTH *(Use a separate sheet for additional dependents)*

	VETERAN	SPOUSE	CHILD 1
1. CASH, AMOUNT IN BANK ACCOUNTS (*e.g., checking and savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds*)	$	$	$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. (*e.g., second homes and non-income producing property. Do not count your primary home.*)	$	$	$
3. VALUE OF OTHER PROPERTY OR ASSETS (*e.g., art, rare coins, collectibles*) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. *Exclude household effects and family vehicles.*	$	$	$

SECTION XI - CONSENT TO COPAYMENTS

If you are a 0% SC veteran and do not receive VA monetary benefits or a NSC veteran (and you are not a Former POW, Purple Heart Recipient or VA pensioner) and your household income (or combined income and net worth) exceeds the established threshold, this application will be considered for enrollment, but only if you agree to pay VA copayments for treatment of your NSC conditions. **If you are such a veteran by signing this application you are agreeing to pay the applicable VA copayments as required by law.**

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.

SIGNATURE OF APPLICANT | DATE

DD Form 214

Review This Form Carefully

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD. SAFEGUARD IT.

DD FORM 214 WORKSHEET

1. NAME (Last, First, Middle)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO.

4.a GRADE, RATE, OR RANK	4.b PAY GRADE	5. DATE OF BIRTH (YYYYMMDD)	6. RESERVE OBLIG. TERM. DATE (Year / Month / Day)

7.a PLACE OF ENTRY INTO ACTIVE DUTY	7.b HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)

8.a LAST DUTY ASSIGNMENT AND MAJOR COMMAND	8.b STATION WHERE SEPARATED

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE ☐ None Amount: $

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.)	12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
	a. Date entered AD This Period			
	b. Separation Date This Period			
	c. Net Active Service This Period			
	d. Total Prior Active Service			
	e. Total Prior Inactive Service			
	f. Foreign Service			

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

14. MILITARY EDUCATION (Course title, number of weeks and month and year completed)

15.a MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERAN'S EDUCATIONAL ASSISTANCE PROGRAM	Yes / No	15.b HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes / No	16. DAYS ACCRUED LEAVE PAID

17. MEMBER WAS PROVIDED A COMPLETE DENTAL EXAM AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION ☐ Yes ☐ No

18. REMARKS

19.a MAILING ADDRESS AFTER SEPARATION (Include Zip Code)	19.b NEAREST RELATIVE (Name and address - include Zip Code)

20. MEMBER REQUESTS COPY 6 BE SENT TO _____ DIR OF VET. AFFAIRS ☐ Yes ☐ No

22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and signature)

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE (Include upgrades)	

25. SEPARATION AUTHORITY	26. SEPARATION CODE	27. REENTRY CODE

28. NARRATIVE REASON FOR SEPARATION

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4 _____ Initials

DD Form 214WS, NOV 88 — Previous editions are obsolete. — WORKSHEET

BLOCK #17

☑ NO

What happens after I submit my enrollment application form to VA?

- You will receive a letter in the mail from VA approximately 2-3 weeks after you are discharged from service.
- This letter will tell you that you have been enrolled into VA health care at the facility you selected on your enrollment form. It will also tell you how to access medical care at that facility.
- If you need routine health care before you receive your enrollment letter, you will receive today a **Watermark Letter** to show VA staff at the VA Medical Center. You may contact the OEF/OIF Program Manager at the VA Medical Center you selected who will help you with an appointment. If you don't know the phone number of the Medical Center, dial:

1-877-222-8387

Please remember to bring your DD214 with you when you first report to the VA medical center. However, VA will take care of you for your urgent condition immediately even without your DD214.

Medical Benefits Plan

- Screening exams for: Depression, Substance Abuse, PTSD, Military Sexual Trauma, TBI
- Preventive Care Services
- Inpatient and Outpatient Treatment
- Prescription Services
- Women’s Health Program

Dental Care

Cost free one time treatment of dental conditions for recently separated veterans who

- ✓served for 90 days or more,
- ✓apply within 180 days of separation, and
- ✓DD214 does not indicate necessary dental care was provided within 90 days of release or discharge

Women Veteran Programs

- Women veterans may receive
  - full continuum of medical benefits package
  - women's family planning and birth control, gender-specific health care, e.g. hormone replacement therapy, breast and GYN care, maternity, limited infertility
  - Special considerations
    - Each facility has a Women Veterans Program Manager
    - Women's Trauma Recovery Program (Palo Alto) inpatient post traumatic stress disorder (PTSD) and military sexual trauma (MST) treatment
    - VA researchers also conduct studies on women's health
    - Women's Benefits Coordinator available for disability benefits

VA Treatment of Non-Combat Related Conditions

- Veterans Who Experience Non-Service Connected Illness/Injuries Post Deployment may be charged a co-pay at VA for treatment of these conditions ie: flu, colds, auto accident

HelpYour Buddy

VA's
National Suicide Hotline Resource
1-800-273-TALK
(8255)

GI Bill Information

- GI Bill Website:

  http://www.gibill.va.gov/

- How To Apply For Benefits:

  http://www.gibill.va.gov/apply-for-benefits/application/

- Education Benefits Questions:

  1-888-442-4551

questions

Welcome Home